THE J PAUL GETTY TRUST

UnitedHealthcare®

SignatureValue™ Advantage HMO
Offered by UnitedHealthcare of California

HMO Schedule of Benefits

10/250A

These services are covered as indicated when authorized through your Primary Care Physician in your Network Participating Medical Group.

Effective July 1, 2020

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit.	Individual: $1,500 Family: $4,500
PCP Office Visits	$10 Office Visit Co-payment
Specialist Office Visits (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	$10 Office Visit Co-payment
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$250 Co-payment per admit
Emergency Services	$100 Co-payment Co-payment waived if admitted
Urgently Needed Services	
Urgent care services – services provided **within** the geographic area served by your medical group	$10 Co-payment
Urgent care services – services provided **outside** of the geographic area served by your medical group	$50 Co-payment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$250 Co-payment per admit
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Hospital Benefits (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$250 Co-payment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$250 Co-payment per admit
Maternity Care Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	$250 Co-payment per admit
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)** (Only one hospital Co-payment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that admit)	$250 Co-payment per admit
Newborn Care The inpatient hospital benefits Co-payment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.	$250 Co-payment per admit
Physician Care	No charge
Reconstructive Surgery	$250 Co-payment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$250 Co-payment per admit
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	$250 Co-payment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	No charge
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	$150 Co-payment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $10 Office Visit Co-payment $10 Office Visit Co-payment
Ambulance	No charge
Clinical Trials Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply)	$10 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$10 Co-payment per treatment
Durable Medical Equipment In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Family Planning (Non-Preventive Care) Vasectomy Depo-Provera Injection – (other than contraception) PCP Office Visit Specialist Office Visit Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.) Termination of Pregnancy (Medical/medication and surgical) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	 $50 Co-payment $10 Office Visit Co-payment $10 Office Visit Co-payment $35 Co-payment $125 Co-payment
Hearing Aid - Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	No charge
Hearing Aid - Bone Anchored Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.

Benefits Available on an Outpatient Basis (Continued)

Hearing Exam	
PCP Office Visit	$10 Office Visit Co-payment
Specialist Office Visit	$10 Office Visit Co-payment
Co-payments for audiologist and podiatrist visits will be the same as for the PCP. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	
Home Health Care Visits (Up to 100 visits per calendar year) For Infusion Therapy, a separate Infusion Therapy Copayment applies per 30 days	No charge
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services	Not covered
Infusion Therapy (Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Injectable Drugs Outpatient Injectable Medication Self-Injectable Medication (Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician's office, office visit Co-payment/Coinsurance may also apply) FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	No charge
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply)	No charge
Maternity Care, Tests and Procedures	
PCP Office Visit	No charge
Specialist Office Visit	No charge
Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	
Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child)	
Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	$10 Office Visit Co-payment
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing , facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$10 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care	
PCP Office Visit	$10 Office Visit Co-payment
Specialist Office Visit	$10 Office Visit Co-payment
Preventive Care Services (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an “A” or “B” recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Health Care Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form. Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.	No charge
Prosthetics and Corrective Appliances In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Radiation Therapy	
Standard: (Photon beam radiation therapy)	No charge
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and Stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Co-payment amount if any) In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Radiology Services	
Standard: (Additional Co-payment for office visits may apply)	No charge
Specialized Scanning and Imaging Procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure. In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate.	No charge
Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) **Please see outpatient “Mental Health Services” section for cost sharing and services that apply to SMI and SED. Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	

Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder	
Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management	No charge
All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling Customer Service at the telephone number on your ID card.	$10 Co-payment
Vision Refractions	$10 Co-payment

Note: Benefits with Percentage Co-payment amounts are based upon the UnitedHealthcare negotiated rate.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT AND THE UNITEDHEALTHCARE OF CALIFORNIA COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND ADDITIONAL BENEFIT MATERIALS MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A SPECIMEN COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT THE UNITEDHEALTHCARE OFFICE AND YOUR EMPLOYER'S PERSONNEL OFFICE. UNITEDHEALTHCARE'S MOST RECENT AUDITED FINANCIAL INFORMATION IS ALSO AVAILABLE UPON REQUEST.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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Pharmacy Schedule of Benefits

Summary of Benefits	Generic (Tier 1)	Brand Formulary (Tier 2)	Non-Formulary (Tier 3)
Retail Pharmacy Co-payment (per Prescription Unit or up to 30 days) A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	**$15**	**$35**	**$50**
Mail Service Pharmacy Co-payment (three Prescription Units or up to a 90 day supply) A 12-month supply at $0 cost may be provided for FDA-approved, self-administered hormonal contraceptives.	**$30**	**$70**	**$100**

This Schedule of Benefits provides specific details about your prescription drug benefit, as well as the exclusions and limitations. Together this document and the Supplement to the Combined Evidence of Coverage and Disclosure Form as well as the medical Combined Evidence of Coverage and Disclosure Form determine the exact terms and conditions of your prescription drug coverage.

What do I pay when I fill a prescription?

For Prescription Drug Products at a retail pharmacy, you will pay the applicable Co-payment for a Prescription Unit or its retail cost, whichever is less. For Prescription Drug Products from Mail Order, you are responsible for paying the lower of either the applicable Co-payment or the prescription drug cost for that Prescription Drug Product.

You will pay only a Co-payment when filling a prescription at a UnitedHealthcare Participating Pharmacy. You will pay a Co-payment every time a prescription is filled. Your Co-payments are as shown in the grid above.

NOTE: The tier status of a prescription drug can change periodically. Tier status changes resulting in higher Co-payments occur twice per Contract or Plan Year. We will notify you 60 days prior to the change in tiers that will result in a higher co-payment.

Tier changes resulting in lower Co-payments may occur at any time but no more frequent than quarterly. When tier status changes occur, you may pay more or less for a prescription drug depending on the tier placement. You may access Formulary, Non-Formulary, tier placement and Co-payments by calling Customer Service Department 1-800-624-8822 or 711 (TTY) or visiting UnitedHealthcare's Web site at **www.myuhc.com**.

You will receive a written notice 60 days prior to an increase in your Co-payment due to the change in tier placement to move to a higher tier. The notice will inform you of the new tier.

If A Brand-Name Drug Becomes Available as a Generic

If a generic drug becomes available for a brand name drug, your brand name drug's tier placement may change, and therefore your co-payment may change.

Prior authorization

Select Tier 1, Tier 2 and Tier 3 drugs and Non-Formulary drugs require a Member to go through a Prior authorization process using criteria based upon U.S. Food and Drug (FDA) approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are

Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives have been tried. UnitedHealthcare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary.

For a list of the selected medications that require UnitedHealthcare's Prior authorization, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one pre-filled insulin pens**, insulin cartridges and needles for non-disposable pens devices are covered when Medically Necessary in accordance with UnitedHealthcare's Prior authorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend**:** "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs**: Comparable generic drugs may be substituted for brand-name drugs. For brand-name drugs that have FDA approved equivalents, a prescription may be filled with a generic drug unless a specific brand-name drug is Medically Necessary and Prior authorized by UnitedHealthcare, or is on UnitedHealthcare's Selected Brands List. Prior authorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's website at **www.myuhc.com**. If you choose to use a medication not included on the Formulary and not Prior authorized by UnitedHealthcare, you will be responsible for the full retail price of the medication. You will not pay a rate higher than UnitedHealthcare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Prior Authorized by UnitedHealthcare. If it is approved, you will only pay your brand-name Co-pay.
- **Miscellaneous Prescription Drug Coverage:** For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to EpiPen®, Ana-Kits®, and Ana-Guard®). See the medical Combined Evidence of Coverage and Disclosure Form for coverage of other injectable medication and equipment for the treatment of asthma in Section Five under "Your Medical Benefits".
- **Oral Contraceptives:** All FDA-approved contraceptives, drugs, devices, and products are covered at $0 cost sharing subject to therapeutic equivalents that may be prescribed and may be subject to prior authorization. A Member may receive a 12-month supply of an FDA-approved, self-administered hormonal contraceptive dispensed or furnished at one time by a provider or from a contracted pharmacy that has agreed to dispense or furnish FDA-approved contraceptives in accordance with state and federal law. To determine whether the Plan's contracted pharmacy provides for a pharmacist to dispense FDA-approved contraceptives directly, please contact the contracted pharmacy or call the Plan at the number shown on your card. Please refer to the medical combined Evidence of Coverage and to your Outpatient Prescription Drug Supplement for more information.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only according to State law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff is not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer

to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for more information about medications covered under your medical benefit.

- **Compounded medication**: Any Medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Prior authorized as Medically Necessary by UnitedHealthcare.
- **Diagnostic drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or non-prescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Drugs prescribed solely to treat hair loss.**
- **Enhancement medications** when prescribed for the following non-medical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical®, or Meridia®. This exclusion does not exclude coverage for drugs when Prior authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for additional information.
- **Injectable medications**: Except as described under the section "Medications Covered By Your Benefit", injectable medications including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Prior authorization requirements. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form under "Your Medical Benefits".
- **Inpatient medications**: Medications administered to a Member while an inpatient in a hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form entitled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy, and pay the applicable Co-payment on behalf of the Member.
- **Investigational or Experimental drugs:** Medication prescribed for Experimental or Investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.

- **Medications dispensed by a Non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by Non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost effectiveness and approved** by UnitedHealthcare are not covered unless Prior authorized by UnitedHealthcare as Medically Necessary.
- **Non-covered medical condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-covered services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-label drug use**. Off-label drug use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical Combined Evidence of Coverage and Disclosure Form and any applicable Attachments. If a drug is prescribed for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) The American Hospital Formulary Service Drug Information, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen; (i) The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; (iii) The Thompson *Micromedex DRUGDEX System, or (c)* Two articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in major peer-reviewed medical journal. Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Co-payment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.
- **Over-the-Counter Drugs:** There is an exclusion of Over the Counter Drugs whether prescribed or not unless they are on UnitedHealth care's formulary or unless they are FDA-approved tobacco cessation drugs and products, or FDA-approved contraceptives, drugs, devises or other products both of which are provided as preventive benefit at $0 cost sharing subject to certain exception. For more information regarding coverage of certain over the counter drugs on the formulary, please see your Outpatient Prescription Drug Supplement and your Combined Evidence of Coverage under Family Planning and Tobacco Screenings. You may also contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**. Additionally, FDA-approved over-the-counter smoking cessation drugs prescribed by your Physician and female contraceptive methods are covered as preventive. For information regarding coverage of certain over the counter drugs including those on the formulary please contact UnitedHealthcare's Customer Service Department at 1-800-624-8822 or 711 (TTY) or view online at **www.myuhc.com**. Prescription Drug Products that are comprised of identical active ingredients and dosage that are available over-the-counter are not covered except when Medically Necessary. This exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- **Prior to Effective Date**: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen, or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section Five for additional information.
- **Sexual dysfunction medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to erectile dysfunction, impotence,

anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra®.

- **Smoking cessation products** unless they are FDA-approved tobacco cessation drugs and products, both of which are provided as a preventive benefit at $0 cost sharing subject to certain exception. For information on UnitedHealthcare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits, in the section entitled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our web site at **www.myuhc.com**.
- **Therapeutic devices or appliances** including, but not limited to, support garments and other non-medical substances, insulin pumps and related supplies (these services are provided as durable medical equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical Combined Evidence of Coverage and Disclosure Form in Section Five, entitled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections entitled "Diabetic Self Management", "Durable Medical Equipment", or "Home Health Care and Prosthetics and Corrective Appliances".
- **Worker's Compensation**: Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about Workers Compensation can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Six under "Payment Responsibility".

  UnitedHealthcare reserves the right to expand the Prior authorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or 711 (TTY).

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com

PCA757891-005
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CALIFORNIA

UnitedHealthcare®

Chiropractic Schedule of Benefits Offered by ACN Group of California, Inc.

Benefit Plan:

$10 Copayment per Visit

30 Visit Annual Maximum Benefit

UnitedHealthcare of California makes available to you and your eligible dependents programs that are included as part of your coverage chiropractic benefit. This program is provided through an arrangement with the ACN Group of California, Inc. d/b/a OptumHealth Physical Health of California (OptumHealth).

How to Use the Program

With this benefit, you have direct access to more than 3,000 credentialed chiropractors servicing California. You are not required to predesignate a Participating Provider or to obtain a medical referral from your primary care physician prior to seeking chiropractic services. Additionally, you may change participating chiropractors at any time.

If these services are covered services, you simply pay your copayment or coinsurance at each visit. There are no deductibles or claim forms to fill out. Your Participating Provider coordinates all services and billing directly with OptumHealth. Members are responsible for any changes resulting from non-covered services.

Annual Benefits

Benefits include chiropractic services that are Medically Necessary services rendered by an Optum Health Participating Provider. In the case of chiropractic services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Maximum Benefit Limits

Each visit to a Participating Provider, as described below, requires a copayment by the Member. A maximum number of visits per year will apply to each member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without a chiropractic adjustment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the maximum benefit.

Provider Eligibility

OptumHealth only contracts with duly licensed California chiropractors. Members must use OptumHealth Participating Providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the OptumHealth participating chiropractor to determine the nature of the member's problem, and to provide, or commence, in the initial examination, Medically Necessary services to the extent consistent with professionally recognized standards of practice. At that time, a treatment plan of services will be provided. The initial examination will be provided to a Member if the Member seeks services from a participating chiropractor for any injury, illness, disease, functional disorder or condition. A copayment will be required for such an examination.

   Subsequent office visits, as set forth in the treatment plan, may involve a chiropractic adjustment, a brief re-examination and/or a combination of services. A copayment will be required for each office visit.
2. Adjunctive therapy, as set forth the treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
3. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copayment will be required.
4. X-rays and laboratory tests are a covered benefit in order to examine any aspect of the member's condition.
5. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by an OptumHealth participating chiropractor.

Important OptumHealth Addresses:

Member Correspondence

ACN Group of California, Inc.
Attn.: Member Correspondence Unit
P.O. Box 880009
San Diego, CA 92168

Grievances and Complaints

ACN Group of California, Inc.
Attn.: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168

Exclusions and Limitations

Benefits do not include services that are not described under the Covered Services contained elsewhere in the Evidence of Coverage (EOC) provided to a member. The following accommodations, services, supplies and other items are specifically excluded from coverage as referenced in the EOC:

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Any accommodation, service, supply or other item that are not related to the member's condition, not likely to result in sustained improvement, or do not have defined endpoints, including maintenance, preventive or supportive care.
4. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
5. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
6. Experimental or investigative services unless required by an external, independent review panel as described in 16.5 of the EOC;
7. Services provided at a hospital or other facility outside of a Participating Provider's facility;
8. Holistic or homeopathic care including drugs and ecological or environmental medicine;
9. Services involving the use of herbs and herbal remedies;
10. Treatment for asthma or addiction (including but not limited to smoking cessation);
11. Any services or treatments caused by or arising out of the course of employment and covered under Workers' Compensation;
12. Transportation to and from a provider;
13. Drugs or medicines;
14. Intravenous injections or solutions;
15. Charges for services provided by a Provider to his or her family Member(s);
16. Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
17. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
18. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, treatment for an educational requirement, and services relating to sexual transformation;
19. Claims by Providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
20. Ambulance services;
21. Surgical services;
22. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder, unless supplied by the Provider at no additional charge to the Member or to Health Plan;
23. Non-Urgent services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child; and
24. Emergency Services. If a Member believes he or she requires Emergency Services, the Member should call 911 or go directly to the nearest hospital emergency room or other facility for treatment**.** Medical Emergencies are covered by the Member's medical plan.

ACN Group's Web site Address:
http://www.myoptumhealthphysicalhealthofca.com

Customer Service:
1-800-624-8822
711 (TTY)
www.myuhc.com